STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
			A. BUII B. WIN			05/04/2	2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
BENNET	T HOUSE				ORNE AVE LBANY, IN47150		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION DATE
R0000		,		-			
			RO	0000			
	This visit	was for a Post					
	Survey Re	evisit (PSR)to					
	the Invest	igation of					
	Complain	t IN 00088045					
	completed	l on 3/28/11.					
	- not corre	t IN 00088045 ected, state I finding cited					
	Unrelated cited	deficiency					
	Survey da 2011	te: May 4,					
	Facility nu	umber : 004442					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6UT012

Facility ID:

004442

TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Ì		NSTRUCTION 00	(X3) DATE COMPI		
			A. BUIL B. WING			05/04/2	
NAME OF F	PROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP CODE		
BENNET	T HOUSE			l	DRNE AVE LBANY, IN47150		
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	Provider 1	number:					
	004442						
	AIM num	ber: NA					
	Survey te	am:					
	Dorothy N	Navetta, RN,					
	TC						
	Gloria Reisert, MSW						
	Avona Co	onnell, RN					
	Census be	ed type:					
	Residentia	al: 33					
	Total: 33						
	Census pa	ayor type:					
	Other: 33						
	Total: 33						
	Sample: 5	,					
	•						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/04/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	These stat	e residential					
	findings a	re cited in					
	accordanc	e with 410					
	IAC 16.2.						
	•	view l on May 10, Sev Faulkner,					
R0241	(e) The administration provision of reside as ordered by the shall be supervise premises or on ca (1) Medication shall	ation of medications and the ential nursing care shall be resident 's physician and d by a licensed nurse on the ll as follows: all be administered by ersonnel or qualified	R0241	Submission of this response Plan of Correction is NOT a admission that a deficiency or, that this Statement of Deficiencies was correctly ci and is also NOT to be constr as an admission against inte by the residence, or any employees, agents, or other individuals who drafted or madiscussed in the response or	legal exists ted, rued rest ay be		

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE S COMPLI 05/04/20	ETED
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	STREET A 3928 H	DDRESS, CITY, STATE, ZIP CODE ORNE AVE BANY, IN47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
				of Correction. In addition preparation and submiss this Plan of Correction do constitute an admission of agreement of any kind by facility of the truth of any alleged or the correctness conclusions set forth in the allegation by the survey agency. Citation #1 R 02 IAC 16.2 What corrective action(s) will be accomplished for those residents four have been affected by the deficient practice? Resisphysician and family were of the medication errors a medication was obtained administered per the physorder. How the facility identify other residents the potential to be affect the same deficient practive action was administered were reviewed and No of residents were found to be affected. What measures put into place or what schanges will the facility to ensure that the deficient practice does not recurively and procedure regulation Administration obtaining medications, and medication errors. The Wolirector will be responsible ensure medications are a per the physician's order	ion of pes NOT per / the facts s of any his set 141 410 e polished and to his dent D's e notified and the and sician's will having ted by tice and vill be records ther per set will be set will be resed to our arding his not vill per ensed to our arding his not vill per	

PRINTED: 06/03/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	00	CO	MPLETED
			B. WIN	IG		05/0	4/2011
NAME OF PROVIDER OR S	UPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE NEW ALBANY, IN47150				
BENNETT HOUSE (X4) ID SUM PREFIX (EACH E TAG REGULAT	IMARY S DEFICIENT ORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Tecord review	B. WIN	3928 H	ORNE AVE	INTION LD BE ROPRIATE Ind family ine ill be ne not recur, rance to place? and/or sysician ill the on Record liance for he rill review iths to y for addings on the ce will liancy of irector sure of nen a to be to fa negs will be through is. By what changes	(X5) COMPLETION DATE
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6UT012

Facility ID:

004442

If continuation sheet

Page 5 of 16

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE : COMPL		
			A. BUII B. WIN			05/04/2	
NAME OF F	PROVIDER OR SUPPLIER		!	STREET A	ADDRESS, CITY, STATE, ZIP CODE	Į	
BENNET	T HOUSE			1	ORNE AVE LBANY, IN47150		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
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	residents 1	reviewed for	Ī				
	medications in a sample						
	of 5. (Res	ident #D)					
	Findings i	nclude:					
	1. The clinical record for						
	Resident I	D was					
	reviewed	on 5/4/11 at					
	10:30 a.m						
	The reside	ent's diagnoses					
	included,	but were not					
	limited to:	: atrial					
	fibrillation	n,					
	cerebral v	ascular					
	accident (stroke),					
	hypertens	ion,					
	hyperlipid	lemia, edema,					
	depression	n, dementia,					
	and anemi	ia.					

	li l) PROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE COMP 05/04/	PLETED
	PROVIDER OR SUPPLIER		3928 H	ADDRESS, CITY, STATE, ZIP C ORNE AVE LBANY, IN47150	CODE	
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	level 11.3.	lood work,				
	the resident the facility from a skill	returned to on 4/7/2011 ed nursing n a new order 150 (m.g.) 1 outh (p.o.)				
	Review of t Medication Administra					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			AULTIPLE CO	NSTRUCTION 00	COMPI	
		B. WI	ILDING NG		05/04/2	2011
NAME OF	PROVIDER OR SUPPLIER	•	1	DDNE AVE	•	
BENNET	T HOUSE		3928 HORNE AVE NEW ALBANY, IN47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	(MAR) from 4/7/11,					
	included the medication					
	Niferex 150 milligrams					
	(m.g.) to be given by					
	mouth (p.o.) 1 tablet					
	daily. There was no					
	documentation on the					
	MAR from 4/11/11 to					
	5/4/11 to indicate the					
	medication had been					
	given.					
	Review of nursing notes indicated Resident D's family member was notified on 4/28/11 the pharmacy was not going to fill the prescription for Niferex 150 m.g. due to the fact the medication					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY IPLETED 1/2011
	PROVIDER OR SUPPLIER	<u> </u>	STREET A 3928 H	ADDRESS, CITY, STATE, ZIP CO ORNE AVE LBANY, IN47150)DE	
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	was availa	able over- the-				
	counter (0	OTC).				
	Review of orders on indicated could take available. Pharmacy document Doctor was Pharmacy to fill the due the far purchased. In an interwellness 5/4/11 at 5	f Doctor's 4/8/11 Resident D e Niferex when from There was no ation the as notified the was not going prescription ct it could be				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMPL		
			A. BUI B. WIN	LDING IG		05/04/2011	
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	P. ,,,,,		DDRESS, CITY, STATE, ZIP CODE		
	T HOUSE	•		1	DRNE AVE		
		TATEMENT OF DEFICIENCIES		<u> </u>	_BANY, IN47150 		(V5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	should be	notified even					
	when one	dose is missed.					
	This State	e Residential					
	deficiency	y was cited on					
	3/28/2011	. The facility					
	failed to in	mplement a					
	systemic p	plan of					
	correction	to prevent					
	recurrence	e.					
R0349	(a) The facility mu	ıst maintain clinical records					
100019	on each resident.	These records must be					
		the supervision of an acility designated with that					
	responsibility. The (1) Complete.	e records must be as follows:					
	(2) Accurately doc						
	(3) Readily access (4) Systematically						
	() =) = 12						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/04/2011	
	PROVIDER OR SUPPLIEF		1	3928 H	ADDRESS, CITY, STATE, ZIP CODE ORNE AVE LBANY, IN47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
TAG	Based on and intervited facility far Medication Administration (MAR) with document 4/11/11 to 5 resident medication administration administration for the clinical Resident of the clinical Resident	record review riew, the iled to ensure on ration Records ere accurately ed from 5/4/11 for 1 of s reviewed for n ation in a 7 residents. #D) Include: eal record for D was on 5/4/11 at	R	TAG (1)349	Submission of this response Plan of Correction is NOT a admission that a deficiency or, that this Statement of Deficiencies was correctly of and is also NOT to be consumed as an admission against into by the residence, or any employees, agents, or othe individuals who drafted or not discussed in the response of Correction. In addition, preparation and submission this Plan of Correction does constitute an admission or agreement of any kind by the facility of the truth of any fare alleged or the correctness of conclusions set forth in this allegation by the survey agency. Citation #2 R 0349 IAC 16.2 What corrective action(s) will be accomplis for those residents found have been affected by this deficient practice? Reside physician and family were not the medication errors and medication was obtained an administered per the physicion order. How the facility will identify other residents has the potential to be affected what corrective action will taken? Resident medical rewere reviewed and No other residents were found to be affected. What measures were suffected. What measures were suffected.	legal exists sited, trued erest or Plan of NOT one exts of any 410 shed to int D's notified of the not cian's I ving d by e and be exords or vill be	06/15/2011
	10:30 a.m				put into place or what sys changes will the facility m		

NAME OF PROVIDER OR SUPPLIER BENNETT HOUSE WHO SUMMARY STATEMENT OF DEFICIENCIES PREDIX TAG The resident's diagnoses included, but were not limited to: atrial fibrillation, cerebral vascular accident (stroke), hypertension, hyperlipidemia, edema, depression, dementia, and anemia. Review of the April and May 2011 MAR's indicated the resident returned to the facility on 4/7/2011 from a skilled nursing facility with a new order for Niferex 150 milligrams (m.g.) 1 tablet by mouth (p.o.) daily for anemia. NIRDIT ADDRINS, CITY, STATIL, ZIP CODE: 3928 HORNE AVE NEWALDANY, INAT150 Description and SARPH NEWALDANY, INAT160 REVIEW OF THE PROPERTY. 3928 HORNE AVE NEWALDANY, INAT160 The resident's diagnoses included, but were not limited to: atrial fibrillation, cerebral vascular accident (stroke), hypertension, hyperlipidemia, edema, depression, dementia, and anemia. To ensure that the deficient practice does not recur? The Wellness Director will be responsible to ensure medications are available per the physician and family notification. How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Wellness Director and/or Designe will review physician orders upon receipt and the Medication Administration Record weekly to ensure compliance for a period of 3 months. The interdisciplinary team will review the findings after 3 months to determine the frequency of monitoring. Wellness Director and family when a medication or physician and family when a medication in the vent of a medication in the vent of a medication or in the vent of a medication	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
BENNETT HOUSE OX9 ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG The resident's diagnoses included, but were not limited to: atrial fibrillation, cerebral vascular accident (stroke), hypertension, hyperlipidemia, edema, depression, dementia, and anemia. Review of the April and May 2011 MAR's indicated the resident returned to the facility on 4/7/2011 from a skilled nursing facility with a new order for Niferex 150 milligrams (m.g.) 1 tablet by mouth (p.o.) daily for anemia. SUMMARY STATEMENT OF DEFICIENCIES (PREFIX TAG PREFIX TAG PREF				B. WIN			05/04/2011		
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PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX PROVIDERS PLAN OF CORRECTION (EACH CORRECTION CEACH CORRECTION CEACH CORRECTION COMPLETED FOR THE APPROPRIATE COMPLETED FOR THE APPROPRIATE COMPLETED FOR THE APPROPRIATE		FOF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 4/2011	
PROVIDERS PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPL				STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE				
1 1	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
The MAR's from April 11,2011 through May 4, 2011 indicated the medication Niferex 150 m.g. had not been initialed and/or circled plus there was no documentation as to why the medication had not been given from 4/11/11 to 5/4/11. Review of nursing records indicated on 4/28/11 nursing staff were aware the pharmacy was not going to fill the order for Niferex due to the fact it		The MAR 11,2011 th 2011 indices medication m.g. had reinitialed a plus there document the medication been given to 5/4/11. Review of records in 4/28/11 nowere aware pharmacy to fill the	I's from April frough May 4, cated the fin Niferex 150 finot been find/or circled fination as to why fination had not fin from 4/11/11 If nursing findicated on fining fire the fire the fination was not going findicated for	TAG			DATE	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		N NUMBER:	MULTIPLE COI	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
			ING		05/04/2011		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3928 HORNE AVE				
BENNETT HOUSE			NEW ALBANY, IN47150				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DE (EACH DEFICIENCY MUST BE PER REGULATORY OR LSC IDENTIFYIN	RCEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	could be purchase						
	the- counter (OTO	C).					
	There was no						
	documentation the	e					
	doctor had been n	otified					
	the medication ha	id not					
	been available or	had					
	been administered	d.					
	In an interview w	ith the					
	WD at 12:00 p.m.	., the					
	WD indicated the	Doctor					
	should be notified	l if					
	even one dose is 1	missed.					
	On 5/4/11 at 12: 2	25 p.m.,					
	the Wellness Dire	_					
	presented a copy	of the					
	facility's current p						
	on "Medication						
	on montement						

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	CON	TE SURVEY MPLETED 1/2011
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CO ORNE AVE	ODE .	
BENNET	T HOUSE			LBANY, IN47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	Administ	ration."				
	Review o	f this policy at				
	this time,	included, but				
	was not li	mited to: "H.				
	MEDICA	TION NOT				
	GIVEN A	\S				
	PRESCR	IBED: 4. If a				
	medication	n is not given				
	for any ot	ther reason:				
	Initial and	d circle the time				
	in the cor	rect space on				
	the MAR	. On the back				
	of the MA	AR, indicate the				
	reason the	e medication				
	was not g	iven."				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		X3) DATE SURVEY COMPLETED 05/04/2011			
			B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER		3928 HORNE AVE				
	T HOUSE		NEW A	LBANY, IN47150			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)		
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE		
		- 9					